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Bioethics

**THE PATIENT, THE DOCTOR, THE FETUS, AND THE COURT-
COMPELLED CESAREAN: WHY COURTS SHOULD ADDRESS
THE QUESTION THROUGH A BIOETHICAL LENS**

V. Chandis* and T. Williams**

The authors would like to thank Arthur Caplan for sharing his wisdom and thoughts in our class and providing us with guidance and insight in writing this comment. Additionally, the authors are grateful for the educational experiences and opportunities the University of Pennsylvania Law School and Center for Bioethics offered them.

Abstract: Court-ordered Cesarean sections are a relatively recent phenomenon in the intersection of law and medicine. Existing jurisprudence utilizes a legal balancing test when addressing conflicts that arise between physicians and patients regarding obstetrical treatment and care. The authors contend that courts' analyses lack a fundamental element – a bioethical framework. Therefore, the authors believe that in order to better assess such conflicts, courts should incorporate a bioethical framework such as the Georgetown mantra to help complement their legal analyses.

Keywords: Court rulings; Cesarean section; bioethics; Georgetown mantra

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INTRODUCTION

A woman's right to control her body has been the center of political, moral, and social debate for many years in the United States. While judicial decisions have narrowed the ability of the state and other parties to restrict a woman's access to abortion in the last three decades, these decisions have not eliminated the larger controversy of the extent to which a woman holds a right to privacy and the control of her own body. Conflicts over these privacy rights have sprung up in other spheres of reproductive control and have yet to be settled via judicial or legislative action, or public debate. One such conflict centers on whether a woman has the right to ignore the advice of her physicians to undergo a Cesarean section ("C-section") for the protection of the child and who, instead, chooses to birth the child vaginally.

Abortion concerns a woman's right to choose to terminate an unwanted pregnancy. But, here, the question becomes: Does a woman in this country have a right to privacy that extends to making an informed decision about whether to attempt a vaginal birth of her full-term child, when serious or fatal consequences exist to both the viable fetus and the mother, rather than having C-section, which could reduce or eliminate those potential risks? Recently, cases in Pennsylvania and Utah have brought this issue into the spotlight. The point at which courts enter the discussion occurs when they are asked to issue an order compelling a mother to have a C-section in situations where the well-being of the fetus and the mother may be at stake. Courts seemingly attempt to use a balancing of interests when addressing this important type of question, which ultimately results in varying outcomes on a case by case basis.

While courts have yet to employ an analysis using the rubrics that bioethics provides, it appears that they are beginning to recognize the need for additional tools when dealing with conflicts between patients and physicians. The outcome of these types of conflicts between the medical community and their patients affects the larger public in its reverberations and the policy that percolates out of these judicial guidelines. Clearly, the time has come to utilize the potential value and effectiveness of a bioethical framework in the Courts. The United States Supreme Court spoke to this need in their 2006 decision of *Gonzalez v Oregon*¹. That case dealt with an Oregon statute which permits physician-assisted suicide under certain regulatory controls. The Federal government attempted to invalidate the state law on the basis that it violated

1. *Gonzales v. Oregon*, 126 S. Ct. 904 (2005).

the Federal Controlled Substances Act and was, therefore, preempted. The Court, however, knew that a basic reading of the statutes involved would only answer a small portion of the most important questions that arise around physician-assisted suicide. Justice Kennedy, in his majority decision stated these concerns this way, “‘Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide.’ The dispute before us is in part a product of this political and moral debate.”² With that call to action, this paper proposes an additional tool for analyzing the conflicts that arise between patients and doctors in medicine, which often later find themselves in the sphere of the courts.

This paper attempts to broaden the scope of a court’s analysis of medically and ethically divisive cases by introducing a bioethical lens under which courts can view the cases in addition to use of legal analysis and precedent. Here, the idea and function of a bioethical lens to be used in the courts is presented using the example of forced C-sections as the focal point of a generally applicable methodology.

The paper is divided into four sections. First, C-sections and the risks involved with them will be discussed generally. Second, the paper will briefly examine the two most recent cases in this area. In section three, an analysis of the jurisprudence arising from these cases is provided. Finally, the issues and problems of forced C-sections (the authors note that this paper does not address ethical questions related to elective C-section operations; rather, it focuses its attention on the bioethical analysis of the court-ordered C-section) will be analyzed under the Georgetown-based framework, which has been widely accepted as an outline of the ethical concerns which must be addressed in clinical settings. While in bioethics, this ethical outline is known as the “Georgetown Mantra,” in this paper, it will be used as a new and compelling bioethical framework that courts should utilize when assessing the various ethical implications in the medical cases before them. This paper concludes that when courts are faced with the question of whether or not to issue an order compelling a C-section against a mother’s will, they should employ both a legal and bioethical analysis, with the latter being borrowed from the commonly accepted “Georgetown Mantra.”

2. *Id.* at

INCREASE IN PREVALENCE OF C-SECTIONS AND THE RISKS ASSOCIATED WITH SURGICAL DELIVERIES

For women in the United States, the chances are greater than ever that they will undergo a C-section when the time comes to give birth. In 1970, 5.5% of women, or roughly one in twenty, underwent the procedure.³ By 2002, the rate had increased to 26.1%, or greater than a one in four chance. The World Health Organization ("WHO") has suggested that a rate of surgical birth above 10%-15% is problematic. In fact, the Center for Disease Control ("CDC") issued a goal of reducing the number to 15% by 2010.⁴ One of the main reasons for the increasing number of C-sections is that the surgery allows women to fit their children's births into the mother's schedule. Giving birth for women that elect to do so is thus on their own terms. This is not the issue that this paper attempts to dissect. It is mentioned because the authors wish for it to be understood that the circumstances that lead to a certain type of birth are varied and individualized. But, as evidenced by the declarations of the WHO and CDC, for many women, C-sections are unnecessary, in many instances unwanted, and can lead to serious adverse side-effects.

The practice of surgical delivery does carry risks. Women delivering via C-section are four times more likely to die during childbirth than their counterparts delivering vaginally. Additionally, it carries the risks that any operation does; these include but are not limited to infection, hemorrhage, the need for transfusion, and anesthesia complications. Surgical delivery may also produce a need for a hysterectomy closely following the surgery and a chance of placental abnormalities in future pregnancies. For the fetus, the surgery increases the likelihood that the baby will be born prematurely and suffer from respiratory distress. Even for the fully-developed fetus ready to deliver at the time the C-section is performed, the lack of active labor may still result in respiratory complications and may increase the likelihood of other complications in the infant.⁵

3. Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court Ordered Cesareans*, 74 Cal. L. Rev 195, 1958.

4. WHO

5. *See supra*, note 3 at 1958.

AN ANALYSIS OF RECENT CASES INVOLVING COURT-ORDERED C-SECTIONS

Recently, two cases arose where hospitals, physicians, and courts attempted to force women to undergo C-sections. Analysis of these examples provides us with a background of the issues arising related to both patients and their physicians in compelled C-section situations. This background helps in developing a better understanding of the larger medical, legal, and social issues that become involved when courts utilize a bioethical framework.

In January 2004, Amber Marlowe went to Wilkes-Barre General Hospital in Pennsylvania to give birth to her seventh child. Prior to their arrival, Mr. and Mrs. Marlowe had been to another hospital and were told that if they chose to deliver there, to protect the fetus's health, Mrs. Marlowe would have to deliver via C-section. The couple left the hospital after refusing to undergo the procedure and headed to Wilkes-Barre General.

At Wilkes-Barre General, after initially approving Mrs. Marlowe for a vaginal birth, her physicians attempted to convince the couple that a C-section was necessary due to the size of the fetus. The hospital ultrasound led them to believe the fetus was close to thirteen pounds. The Marlowes contended that, according to other tests, the fetus was estimated to weigh closer to eleven pounds, and so they insisted on a vaginal birth and left the hospital.

Wilkes-Barre General's fears were not unfounded. There was evidence that a serious complication had occurred in a previous birth of Mrs. Marlowe that could endanger both her life and that of the fetus she currently carried. The hospital's concerns regarding the size of the fetus were also valid standing alone from the previous complications. The physicians and the staff were not aware, however, that the Marlowe's had lost a close friend due to complications arising from a C-section.

After the couple left, Wilkes-Barre General Administrators went to a Pennsylvania court and asked for permission to take guardianship of Mrs. Marlowe's fetus. The order permitted the hospital, if Mrs. Marlowe returned, to force her to undergo a C-section in order to protect "Baby Doe." This was the first order of its kind in the state. In the end, however, despite the valid fears of her physicians at Wilkes-Barre, Amber Marlowe had a safe vaginal birth at another nearby hospital without complication.⁶

6. "Court Delivers Controversy", David Weiss, *Times Leader* (Jan. 16, 2004).

The second case, involved Melissa Ann Rowland, and unfortunately, did not render the same result. In 2004, doctors advised Ms. Rowland, pregnant with twins, on several occasions that she needed to have a C-section to ensure that the health of her unborn children would not be endangered. Ms. Rowland continually refused, but when she went into labor, she did have a C-section. The result, however, was heart-breaking; one of her children was born with serious complications, while the other was stillborn. Had Ms. Rowland undergone a C-section when her doctors originally advised her to, her children would both have been born alive and healthy. Utah authorities originally charged her with murder, to which Ms. Rowland pled not guilty, and the prosecution and the Rowlands later entered into a plea agreement that dropped the murder charge. Ms. Rowland subsequently pled guilty to child endangerment.⁷

The threat of criminal prosecution is undoubtedly an effective means of compelling women in these situations to undergo forced C-sections. However, the process and outcomes occurring in the Rowland case are as morally problematic as those presented in the Marlowe's case. In both cases, hospitals and administrators attempted to override the decision making power of pregnant women and to make their own decisions related to these women's medical care.

Precedents such as these may not only have a problematic legal structure, but also fail to show the way in which an ethically-based clinical analysis would make such decisions. Namely, an ethically-based clinical analysis would provide input from all the necessary and important parties in circumstances like these, including medical professionals, hospitals and their insurers. And, additionally, an ethically-based clinical framework would also give greater weight to the voices of patients, contrary medical evidence and the fundamental principles that the medical establishment has embraced – presented in the Georgetown mantra.

The reader should also be reminded, however, that these two cases are only the most extreme examples of the problem. In many hospitals all over the country, physicians and nurses are not forced to seek the courts' help; they are effectively able to regulate the health choices of women and enable them to deliver vaginally. There is numerous anecdotal evidence of hospital and

7. "Refusal to Undergo a Cesarean Section: A Woman's Right or a Criminal Act?" Monica K. Miller, 15 *Health Matrix* 383 (2005).

physician utilization of leverage and intimidation to prohibit attempts at vaginal birth after a previous C-section has been performed on the mother. This is in addition to hospital policies which prohibit vaginal births after having had a C-section.⁸ The problem here does not concern the safety and efficacy of vaginal births versus C-sections. Rather, the problem is much larger and more intricately linked to the broader rights of women and people in general to control the choices related to their healthcare and our rights to bodily privacy. The two cases do, however, provide excellent examples through which to assess the ethical problems that may be encountered in situations where the rights of patients and physicians conflict.

LEGAL FRAMEWORK AND PRECEDENT

The legal status of a fetus

Although the fetus is not a “person” in terms of constitutional standing,⁹ courts have recognized that “what happens to a viable fetus is a legally cognizable concern.”¹⁰ A few states have criminal statutes that make the culpable killing of a fetus homicide while many states allow for recovery for loss of consortium or wrongful death in the case of an intentionally caused stillbirth.

Additionally, a child can get recovery for injuries it sustained as a fetus and a fetus, at the point of conception, could be an heir to a decedent’s estate as long as the fetus’s rights to the estate materialized upon live birth.¹¹ Thus, it is clear that in certain legal contexts, a fetus is treated as a person.

State interests which courts consider in Cesarean refusal cases

In a string of cases, courts have established that there is a right to “refuse medical treatment as a fundamental principle of autonomy.”¹² However, this

8. “US Hospitals Banning VBAC, Forcing Repeat Cesareans”, International Cesarean Awareness Network, Inc. Press Kit (2004).

8. Joel Jay Finer, Towards Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity, 76 MINN. L. REV. 239, 249 (1991) (discussing the legal status of a fetus).

10. *Id.*

11. See *id.* at 247 (explaining the various ways a fetus enjoys legal rights).

12. Barbara Ann Levine, Court Ordered Cesareans: Can a Pregnant Woman Refuse?, 29 HOUS. L. REV. 185, 203 (1992).

is a qualified right. Courts recognize four state interests that can limit an individual's right to refuse medical treatment. The Courts balance these interests against the patient's right to refuse treatment. The four exceptions are: (i) prevention of suicide, (ii) protecting the integrity of the medical profession, (iii) the protection of innocent third parties, and (iv) the State's interest in preserving life.

Typically, in court-compelled C-section cases, the state's interest in preventing suicide is irrelevant.¹³ This is because while when a woman refuses a C-section, even if her chances of survival are low absent the procedure, it does not mean she intends to take her own life. Also, because doctors cannot perform a surgery on a patient who has not provided informed consent and people have a right to refuse medical treatment, there is little concern about protecting the integrity of the medical profession.¹⁴

The state interests most often invoked when balancing the State's interest and a patient's autonomy in the right to refuse a Cesarean are those concerning protection of innocent third-parties and the state's interest in preserving life.¹⁵ To many, it seems to be the most relevant interest a state has in this area is the protection of third-parties. Typically, this interest is implicated in situations where a parent refuses medical treatment necessary for survival, which would leave minor children who "would potentially become a ward of the state upon a parent's demise" and the "concerns regarding the effect the loss of a parent would have on a child's emotional well-being."¹⁶ Involving this interest in cases of compelled Cesareans is complicated, however, for several reasons. First, a fetus is not a "person" within the meaning of the Fourteenth Amendment. Second, just because a mother chooses to birth vaginally instead of having a C-section does not mean that the child will be abandoned or become a ward of the state. Lastly, it seems likely that the mother choosing to refuse a C-section

13. See Eric M. Levine, Comments: The Constitutionality of Court Ordered Cesarean Surgery: A Threshold Question, 4 *ALB. L. J. SCI. & TECH.* 229, 275 (1994) (listing the four state interests that are considered in right to refuse medical treatment cases and explaining why the state interest in preventing suicide is not a concern in these cases).

14. See *supra* note 4 at 204 (summarizing why this state interest is irrelevant in court-compelled cesarean cases).

15. See *id.* at 204-05 (expanding on the two state interests that are given the most weight when a court employs a balancing test).

16. *Supra* note 9, at 282.

will have little to no impact on the emotional well-being of a fetus that has had no exposure to its mother, its family, or the outside world.

The state interest in preserving life is considered the most important of the four interests. This interest is also complicated when we attempt to apply it to cases where a compelled C-section is sought. On one hand, the state is interested in preserving the life of the patient. On the other hand, the state also has a legitimate interest, expressed in abortion cases, to preserve potential life. Sometimes these interests conflict – such as when the mother has an increased risk of death if a C-section is performed, but the fetus has an increased chance of survival through the operation. Even in situations where a C-section would benefit the mother's health as well as benefit the fetus, debates arise over whether the fetus should be protected because the law already considers the mother's life and her "interest in her bodily integrity should not be outweighed" by the interests of the fetus.¹⁷

Noteworthy cases involving Cesarean refusals

*Jefferson v. Griffin Spalding County Hospital Authority*¹⁸

In *Jefferson*, the mother had a complete placenta previa, but refused to have a C-section because of her religious beliefs. If the mother had the C-section, both she and the fetus's risk of survival were almost 100%, whereas if the mother birthed vaginally, she only had a 50% chance of survival and the fetus was unlikely to survive.¹⁹

The court ordered the C-section because it determined that a fetus has a constitutional right to the state's protection; thus, it is appropriate to infringe on the mother's rights in order to protect the fetus's right to life. In reaching its decision, the court implicitly used the balancing test used in *Roe v. Wade*, but did not explicitly state what weight was given to which factors. Because both the mother and fetus in this case had increased chances of survival with the C-section, the court felt free to override the mother's religious beliefs and rights to privacy and bodily integrity.

17. *Id.* at 287.

18. *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981).

19. See Annette Williams, Comment: In re A.C.: Foreshadowing the Unfortunate Expansion of Court-Ordered Cesarean Sections, 74 *IOWA L. REV.* 287, 291 (1988) (summarizing the facts of the case).

*In re Madyun Fetus*²⁰

This case concerned a Muslim mother who refused to consent to a C-section because of her religious beliefs. The fetus had a 50%-75% of contracting fetal sepsis without surgical delivery, which could result in fetal death, but the mother had an almost 100% chance of surviving the operation. Therefore, the court ordered the operation because there were minimal risks to the mother and significant risks to the fetus if the surgery was not performed.²¹ Both mother and fetus survived.

*In re A.C.*²²

This case involved a 27-year old pregnant woman who was terminally ill. In her twenty-fifth week of pregnancy, her health deteriorated rapidly and she agreed to palliative care to extend her life span, even though the treatment posed some risks to the fetus. A.C.'s health quickly deteriorated and she required intubation and heavy sedation, which prevented her from communicating about her intentions regarding the fetus. The hospital went before the trial court and asked it to order a Cesarean, even though A.C.'s wishes were not clear.

The lower court ordered the Cesarean after concluding that the fetus had a 50%-60% chance of survival if a C-section was performed and that because the fetus was viable, the state had an interest in protecting the potential human life, even though the surgery would hasten A.C.'s death.²³ The District of Columbia Court of Appeals denied the motion to stay the trial, the court order was carried out and the C-section was performed. Shortly after, A.C. and her child both died. Four months later, the D.C. Court of Appeals, rehearing the cases en banc, vacated the trial court's order because it recognized a patient's right to consent to a C-section. And, if the woman is unable to consent to the operation due to incapacitation and her wishes are unknown, then substituted judgment must be used to figure out her decision, rather than the balancing

20. *In re Madyun Fetus*, 114 Daily Wash. Law Rptr. 2233 (D.C. Super. Ct. 1986).

21. See *supra* note 9, at 292 (summarizing the reasoning of the court's decision).

22. *In re A.C.*, 573 A.2D 1235 (D.C. 1990) (en banc).

23. See *supra* note 5, at 242 (discussing the factors the trial court considered in determining whether to order the cesarean).

test applied by the trial court.²⁴ The court focused on theories of informed consent and the importance of the doctor-patient relationship between the woman and her clinician.

*Baby Boy Doe v. Mother Doe*²⁵

Here, the mother was four to five weeks from full term when her doctor discovered that the fetus was receiving an inadequate oxygen supply. The mother refused a C-section on religious grounds. Both the trial, appellate, and state supreme courts refused to compel the mother to undergo a C-section, claiming there was no precedent for compelling a woman to undergo the surgery in order to save the fetus.²⁶ Honoring the "...woman's competent choice to refuse medical treatment as invasive as a C-section during pregnancy must be honored, even in circumstances where the choice may be harmful to the fetus,"²⁷ is of utmost importance based on the decision handed down by the court in this case.

*Pemberton v. Tallahassee Memorial Regional Medical Center*²⁸

The mother in this case already had a C-section with one of her children and did not wish to have the operation again. After being told by a number of physicians that she would not be able to birth her child vaginally because of the previous surgery, she decided to deliver the child at home. After more than a full day of labor, the mother became dehydrated and could not hold down food or water, and she and her husband went to the hospital. Physicians there refused to give her an IV because they believed she needed to undergo a C-section and proceeded to get a court order to do so, even though the expectant mother had left the hospital. The judge ordered her to return to the hospital, and she was brought from her house, against her will, by a police officer. At the hospital, she expressed her views to the judge, but he still ordered the C-section and the operation was performed.

24. See *id.* at 243 (explaining the appellate court's reasoning for vacating the trial court's order).

25. *Baby Boy Doe v. Mother Doe*, No. 1-92-4322, 1994 WL 111529 (Ill. App. Ct. Apr. 5, 1994).

26. See *supra* note 9, at 248-49 (discussing the courts' holdings and reasonings for not ordering the cesarean).

27. *Supra* note 25, at *1.

28. *Pemberton v. Tallahassee Memorial Regional Medical Center*, 66 F. Supp. 2d 1247 (1999).

The mother claimed, in federal court, that the operation and the procedure that led to it were violations of her procedural and substantive due process rights. The court determined that it did not have the authority to review the procedures of a state court and that the mother's personal constitutional rights did not outweigh the state's interest in preserving potential life. The court felt there was a risk to the fetus's health because of the advice the mother initially received from the doctors and that because the birth of the baby was imminent. The imminence of the birth made an even stronger case of preserving the potential life of the unborn child because it indicated her intention to attempt carry the pregnancy to term. Had the mother not wanted the child, the court would have weighed her rights more heavily because "bearing an unwanted child is surely a greater intrusion on the mother's constitutional interests than undergoing a Caesarean section to deliver a child that the mother affirmatively desires to deliver."²⁹

FORCED C-SECTION CASES DECONSTRUCTED UNDER A BIOETHICAL ANALYSIS USING THE GEORGETOWN FRAMEWORK

When a physician treats his patient, a common analytical framework employed when deciding on the course of treatment is the Georgetown Mantra, which derived from the Belmont report.³⁰ This framework asks the physician to consider four ethical principles when assessing the patient and potential treatment – autonomy, beneficence, non-maleficence, and justice.³¹ While these four principles might not always cover every moral issue that may arise in determining the course of treatment, they are a good starting point to consider the issues presented by court-ordered C-sections.

Courts, it seems, in their analysis of whether to compel a C-section, overlook the relationship that exists between the patient and her doctor. This relationship places ethical duties on the physician in treating his patient that differ from their legal duties and establishes an important set of expectations that a patient

29. *Id.* at 1251.

30. The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (April 18, 1979), available at <http://ohsr.od.nih.gov/mpa/Belmont.php3>.

31. Georgetown Mantra elements

has regarding the relationship.³² The authors believe it is imperative for courts to incorporate a bioethical framework in its analysis in addition to the legal analysis it already uses. This ensures that the courts do not neglect the importance of the patient-physician relationship when assessing the case. Because the Georgetown Mantra is the common framework doctors use in addressing the ethical issues related to treatment and care, we propose those ethical considerations as a starting point for establishing a bioethical framework courts can employ; we do not suggest that a court's bioethical analysis must be limited to the four principles of the Georgetown Mantra. It is through this bioethical lens that courts' analysis will be more complete because it will have considered the ethical implications affecting all of the parties involved to determine the most ethically and legally sound solution to the issues presented in deciding whether to compel a C-section when the fetus or mother's health may be in danger.

The Principle of Autonomy

The Principle of Autonomy or, respect for persons, insists that individuals be left to make their own decisions regarding their medical care.³³ This principle forms the backbone of the informed consent doctrine, which mandates that physicians accurately disclose and discuss the risks and benefits associated with a medical procedure prior to gaining consent of any competent person, and allow the patient to determine what courses of medical care she will accept.³⁴

Most of the forced C-section cases involve competent women who have been informed by their physician what is the best course for delivery. With the exception of *In re A.C.*, all of the women were able to make informed decisions; courts have correctly focused on whether there was consent for treatment on the part of the mother when addressing the issue. Current thinking in the field of obstetrics and gynecology, however, dictates that the mother is not the only patient to be considered when determining care during labor and pregnancy. The verge-of-life fetus child is also a patient and of concern.³⁵ The question then becomes whether the autonomy of the mother should be deemed secondary

32. Doctor Patient Relationship

33. See *supra* note 30, at 4.

34. *Id.* at 6.

35. See *supra* note 3, at 1955-6.

to that of the fetus and, if so, at what point in time. The invasiveness of the procedure and its own risks does not make this question nearly as easy to answer as it at first seems, which is why courts should introduce a bioethical framework into their analyses to help them answer these tough ethical decisions regarding medical case cases.

When faced with whether to compel a C-section, a court should consider the principle of autonomy from a bioethical viewpoint. Respect for autonomy, here, dictates that the physician must respect a competent patient's fully informed choices. Weighing the question of who is the competent patient in a situation like this from a bioethical standpoint would help a court make this determination after careful consideration from different angles. On one hand, a court could find that it is only the mother who is the patient since she can voice and express her wishes and, therefore, the court should focus on the mother's expressed wishes; however, as noted above, the field of obstetrics considers the fetus a patient when providing medical treatment to the mother. Engaging in a bioethical analysis of autonomy might help a court determine such questions as whether an increased rate of survival for the fetus if a C-section is performed is a strong enough consideration to override a competent woman's right to control the process of birth. And, in cases where the woman is not competent to make a decision, or her decision is unknown, the court should not just rely on a legal balancing test of the parties' and state's interest, but also look to the other principles of a bioethical framework to aid in its decision-making process.

Considering autonomy from a bioethical standpoint would also help broaden the court's thinking about tangential issues. For instance, a bioethical issue that possibly could be raised if the court were to consider the fetus a "competent person" whose interests overshadow a competent patient's right to autonomy is the emergence of a slippery slope. The bioethical framework of autonomy would ask courts to consider where and when the line gets drawn in determining which medical procedures a woman can be forced to have if the fetus's potential life is threatened, since the fetus would be considered a competent person. Conversely, if a court determined that the mother's autonomy overrides a fetus's, is there any situation where the fetus would be considered a patient whose well-being overrides the mother's, or any situation where the fetus would be thought of as competent? Utilizing the bioethical principle of autonomy in court's analyses would force a shift to a more substantively complete study of cases.

The Principles of Non-maleficence and Beneficence

The second and third principles of the framework are those of non-maleficence – doing no harm unto the patient – and beneficence – one should only do good unto their patients.³⁶ When faced with deciding whether to compel a C-section, courts, in some ways, pit these two values against each other. This problem has arisen in large part due to the standard of care in obstetrics.

Current standard practices in obstetrics dictate that the physician is responsible for two patients, the mother and the verge-of-life fetus, but this has not always been the case. With increased technology and ability to care for smaller, younger fetuses while they are still inside the womb, there seems to have been a gradual shift to the physician's care of both the fetus and the mother. This heightened level of attention to fetal health, as a woman comes closer to term, presents a conflict of interest for obstetricians, which is critical to this analysis.³⁷ If the physician must concern himself with doing no harm, or doing good, to both the mother and the verge-of-life fetus, conflicts arise when their interests diverge. For instance, a doctor might find himself torn when the fetus has a greater chance of survival if the mother undergoes a C-section whereas the mother also faces a poor chance of survival with a C-section; performance of a C-section by the doctor would be doing good to the fetal patient, but at the cost of doing harm to the maternal patient.

Rather than just focusing on the state's interests as compared to the mother's, the court should use the bioethical analysis to consider a patient's rights and a doctor's duties. First, a court should consider whether a physician can separate and balance the interests of the mother and the verge-of-life fetus. If not, a simple solution may be assigning a physician to each of the two patients to act as their advocates when these situations arise instead of just compelling a C-section. This would permit the medical facility to act to resolve such conflicts internally and with no other interests in mind but the patients'. Additionally, courts should also consider the physicians' interest in limiting the risk of tort liability, which may lead them to assess risk more drastically and more readily abrogate the rights of the mother to ensure an outcome that leaves them guarded from liability.³⁸ Even where the physician is from a non-affiliated hospital,

36. See *supra* note 30, at 4.

37. See *supra* note 3, at 1958.

38. Physician's perceptions of increased liability

the decision is likely to be clouded by this impression of liability. Lastly, even if an obstetrician could be one hundred percent correct that an event would occur and endanger the fetus, forcing a C-section ignores the possibility that statistically, C-section surgery also presents some danger to the mother.

Further, it should be recognized that each side can use statistics to support their arguments and interests and thus, statistics should be taken into account along with bioethical principles. In *Pembroke*, the court stated that statistical probabilities were important in the resulting decision. At the same time, the facts presented by the plaintiff's expert medical witness at trial regarding the likelihood of mortality in mother and child in cases of placenta previa were also deemed reasonable though he presented very different conclusion and probabilities than those relied upon by the hospital.³⁹ His assessment was disqualified only because he was not present at the time of the initial court order to challenge the liability fears of the treating physicians and the hospital. Use of this type of statistical information is a poor way to ensure that cases presented to a judge represent fair and balanced accounts of the conditions present in these time sensitive situations. Courts need a more balanced and reasonable measure of understanding the moral and clinical implications that forcing women to undergo surgery places on the more general rights of patients to make choices regarding their care.

Asking hospitals and courts to veer away from mandates insuring the lowest probabilities of maternal and child death is a difficult task. However, using statistics to mandate a 'one size fits all' clinical scheme to make decisions about obstetric care should bow to a more individually focused and ethically based measure of appropriate, responsible medical care. The Georgetown framework presents an adequate means of beginning a policy discourse that better takes into account all of the important conditions at play in a particular circumstance.

Courts should consider the bioethical principles of beneficence and non-maleficence in their analysis because it will help them gain a better perspective of the situation from *both* the patient and doctor. Doctors have an ethical obligation to not harm their patients, and to do good by them and courts should respect this ethos of the medical profession by weighing it in their analysis. The state and the court are outside observers and without utilizing a bioethical analysis, they will never gain a full understanding of the situation before them.

39. See *supra* note 28, at 1253.

Using these principles as points of analyses will help courts focus on the real issue – the patients and their rights.

The Principle of Justice

The final tenet of the bioethical framework is justice, which mandates “fairness in distribution” and aims to achieve social justice.⁴⁰ It is important for a court to consider this principle in its decision-making process because the court’s decision could have a larger affect on society as a whole. First, without going into too much detail because the subject could be an entire paper on its own, the court should consider how race and class may weigh in decisions to seek to compel a C-section. Of the cases mentioned earlier, the majority involved minority or poor women. Courts should be concerned about the possibility that specific races or the indigent are more likely to be forced to have a C-section because these groups of women could be mis- or uninformed, not have a full understanding of the law or the consequences of the operation, have poor doctor-patient communication and relationships, or have a lack of available medical options due to immobility. It is unlikely that a poor woman would be able to go from one hospital to another until a hospital let her birth vaginally like Mrs. Marlowe was able to do. Therefore, the courts need to consider this fourth bioethical principle in order to help prevent the exploitation of minorities and the poor.

Another concern raised under the justice principle is the father’s desires. A father is responsible for half of the genetic make-up of the fetus and is usually an integral part of the fetus’s life when it comes to term. Thus, in order to have a complete analysis, a bioethical framework would have the court consider the father’s interests. In most cases, it seems that the father’s interests would align with the mother’s. She is not deciding whether to terminate the pregnancy, but the method of delivery. It is easy, however, to envision scenarios where their interests may conflict. In these situations, a court should understand the father’s interest to get the full picture.

Concerns over the number of minority and indigent women being compelled to have C-sections and paternal interests at stake in these cases are only two of the numerous policy issues forced C-section cases raise. Because compelling a woman to undergo a C-section is a serious decision for the courts, they

40. See *supra* note 30, at 5.

should thoughtfully include the bioethical principle of justice to help ensure that their public policy analyses have carefully considered all of the ramifications of their decision on the relevant parties and the public-at-large.

CONCLUSION

Courts faced with the question of whether to compel a C-section, even if the mother is competent, have a hard decision to make because a potential life is involved. Although a legal framework has provided courts with an effective way to look at these types of cases, we believe courts should not restrict their analyses to legal issues, especially with the constant changes in technology and medicine, which renders the field of obstetrics to always be evolving.

While we note that a court's bioethical framework need not be limited to just the ethical principles derived from the Georgetown Mantra nor need it even include those specific principles, we do believe that utilizing some type of bioethical framework would provide the court with a more complete picture of the interests of the parties involved, mainly the patient and the doctor. Beyond that, a court's public policy considerations would be further enriched by pondering the ethical implications for the parties and third-parties, and how a court's decision whether to compel a C-section could have larger social, medical, and political impact beyond the parties to the case.

Thus, we strongly urge courts to employ a bioethical framework as a complement to their legal analyses when faced with cases concerning the possible order to compel a C-section against a mother's wishes when either the maternal or fetal health is at stake.